Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR JAMES T ROBISON IV
5656 BEE CAVES ROAD SUITE M301
AUSTIN TX 78746

Respondent Name
INDEMNITY INSURANCE CO OF NORTH AMERICA

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-13-0680-01

MFDR Date Received
NOVEMBER 13, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I am including an article about billing guidelines for CPT code 69990 that shows this code (when used appropriately) can been billed separately rather than bundled with another procedure code. CPT code 69990 is also considered an 'add on code' to CPT code 64776 and should NOT be bundled."

Amount in Dispute: $1,030.75

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines. See attached EOBs. **Also**, please see the letter from Coventry dated 11/29/12 supporting the fee adjustment rationale."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 24, 2012	CPT Code 69990	$1,030.75	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - U693-By clinical practice standards, this procedure is incidental to the related primary procedure billed.

Issues

1. Is the allowance of the disputed service included in the allowance of another service billed on the disputed date ? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for CPT code 69990 based upon reason codes “97 and “U693.”

   On the disputed date of service the requestor billed CPT codes 26055, 69990, 64704-51, 64776-51, and 26055-51.

   CPT code 69990 is defined as “Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure).”

   28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

   Per the National Correct Coding Initiatives (NCCI) CPT code 69990 is a component of code 64704. The modifier indicator for this code pair indicates a “0.” A modifier indicator of “0” is defined by NCCI as “There are no modifiers associated with NCCI that are allowed to be used with this code pair; there are no circumstances in which both procedures of the code pair should be paid for the same beneficiary on the same day by the same provider” ; therefore, the respondent’s denial reason is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	08/15/2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.